**Delaware Technical Community College**

**Nursing Department**

\*Indicates a critical behavior that must be performed in order to pass the skill successfully.

**Suctioning the Tracheostomy: Open System**

**Goal: The patient will exhibit improved breath sounds and a clear, patent airway.**

1. Check the primary care provider’s order for suctioning. Suctioning typically is performed Q2h and PRN. Collect your supplies: a trach suction kit, a bottle of sterile saline solution, a nonsterile drape for the patient’s chest, stethoscope and your PPE.
2. Check the patient’s chart for any allergies. Provide privacy and perform hand hygiene.
3. Identify the patient. If the patient cannot speak, you must bring something from the patient’s chart with their name, date of birth AND medical record number on it. All 3 unique patient identifiers must match the patient’s arm band. Confirm the patient’s allergies, if any.
4. Tell the patient you are there to perform trach suction, even if the patient does not appear to be alert.
5. Adjust bed to comfortable working position. Lower side rail closer to you. If patient is conscious, place him or her in a semi-Fowler's position. If patient is unconscious, place him or her in the lateral position, facing you.
6. \*Complete a full respiratory assessment. This includes, auscultating lung sounds 6-8 places both anteriorly and posteriorly, looking at the patient’s chest to assess work of breathing, obtaining a full set of vital signs and assessing the skin color around the mouth.
7. You must assess the patient’s respiratory status and tolerance of suctioning continuously throughout the procedure. Don your PPE. Place towel or waterproof pad across patient's chest.
8. Move the bed table close to your work area. The table must be clean, dry and waist high. Place a trash receptacle within easy reach of work area.
9. Turn suction to appropriate pressure (per hospital policy). Typical for a wall unit is 100-120 mm Hg.
10. Occlude the end of the connecting tubing with a gloved hand to check suction pressure. Place the connecting tubing in a convenient location. If using it, place resuscitation bag connected to oxygen within convenient reach. Remove the clean glove and perform hand hygiene (with gel at the bedside). If you need to leave the bedside to do this, the bed must be in the lowest position and the side rails must be up.
11. Open sterile suction package using aseptic technique. Carefully remove the sterile fluid container, touching only the outside surface, not the inner lining. Set it up on the work surface and pour sterile saline into it.
12. Put on sterile gloves. The dominant hand will manipulate the suction catheter and must remain sterile. The nondominant hand is considered clean rather than sterile and will control the suction valve (Y-port) on the catheter.
13. With dominant hand, remove sterile catheter from envelope. Pick up the connecting tubing with the nondominant hand (this hand is now clean, not sterile) and connect the tubing and suction catheter.
14. Test the suction in the catheter and moisten the catheter tip by dipping it into the container of sterile saline. Occlude Y-tube to check suction.
15. Remove trach collar with your nondominant hand. Using your nondominant hand and a manual resuscitation bag, oxygenate the patient delivering three to six breaths at the patient’s rate of breathing. This is done because as we suction, we are removing oxygen from their lungs along with the secretions.
16. Do not occlude Y-port when inserting catheter. Using your dominant hand, gently and quickly insert the catheter into trachea. Advance the catheter until you meet resistance. This is the carina, the point of bifurcation of the bronchial trees. Pull back the catheter about 1” BEFORE applying suction.
17. Apply suction by intermittently occluding the Y port on the catheter with the thumb of your nondominant hand while you gently rotate and withdraw the catheter. Do not suction for more than 10-15 seconds each time. Continuously assess how your patient is tolerating the procedure.
18. Replace the trach collar using your nondominant hand.
19. Assess the secretions in the catheter tubing for “COCA” color, odor, consistency (thin, thick or tenacious), and amount (scant, moderate or copious). Clear secretions from the catheter by suctioning a small amount of saline. Assess effectiveness of suctioning and repeat two more times.
20. Allow at least 30 seconds between each suction attempt. No more than three suction passes should be made per suctioning episode.
21. Remove the patient’s drape. Turn off the suction machine. Remove gloves from dominant hand over the coiled catheter, pulling it off inside out. Remove glove from nondominant hand and dispose.
22. Perform a post respiratory assessment. This includes, auscultating lung sounds 6-8 places both anteriorly and posteriorly, looking at the patient’s chest to assess work of breathing, obtaining a full set of vital signs and assessing the skin color around the mouth. If the patient is not doing better, pulse ox has not increased to within normal limits and they show signs of respiratory distress, you must call respiratory therapy STAT!
23. Return bed to the lowest position. Assist patient to a comfortable position. Raise the side rail. Ensure the call bell is in place and the bed is locked.
24. Perform hand hygiene.
25. Document the procedure to include the pre-respiratory assessment, including auscultation of lung sounds 6-8 places both anteriorly and posteriorly, looking at the patient’s chest to assess work of breathing, a full set of vital signs and the skin color around the mouth, that you suctioned the trach using a 14 fr suction catheter, the number you noted for the depth of the catheter after pulling back 1”, the characteristics of the secretions (COCA), how the patient tolerated the procedure, and the post-respiratory assessment, including auscultation of lung sounds 6-8 places both anteriorly and posteriorly, looking at the patient’s chest to assess work of breathing, a full set of vital signs and the skin color around the mouth.

Adapted: Burton, M. & Smith, D (2023). *Davis Advantage for Fundamentals of Nursing Care: Concepts, Connections, and Skills.* Philadelphia, PA: FA Davis